REPUBLIC OF KENYA
MINISTRY OF HEALTH

Cervical Cancer Screening Card

Facility Name: _____

County Name: _____

Facility Phone No: _____

Client Name: _____

Date of Birth (dd /mm /yyyy)_____ /_____ /_____

Client Phone No: _____ Client Number: _____

Cervical Cancer Screening Card

Date of Visit	Screening Test Performed	Results	Treatment Given e.g Cryo, LEEP

HCP: Health

	Date of Treatment	Remarks	Return Date	HCP Initials

DIVISION OF REPRODUCTIVE HEALTH

head_drh@dfh.or.ke